STATE OF WASHINGTON
DEPARTMENT OF HEALTH

APPLICATION FOR EXPIRED CREDENTIAL ACTIVATION

INSTRUCTIONS

When your application for expired credential activation is received by the Department of Health, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process. This is the only notice you will receive while your application is pending. Applicants are discouraged from calling to check on the status of an application until receipt of this acknowledgment. Your cooperation is requested to permit program staff to prepare your file and re-activate your license at the earliest possible time.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist: **TOTAL FEE DUE IS $120.00**

- ☐ Pay $40.00 Late Penalty Fee. **(All fees are non-refundable)**
- ☐ Pay $40.00 Current Renewal Fee. **(All fees are non-refundable)**
- ☐ Pay $N/A Substance Abuse Monitoring Surcharge. **(All fees are non-refundable)**
- ☐ Pay $40.00 Expired Credential Reissuance Fee. **(All fees are non-refundable)**
- ☐ ***Box #1 Demographic Information.***

  Name: Please list your current name with middle initial.

  Residential Address: Please identify the address to which you wish all correspondence, including you credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

  Telephone Number: Enter current telephone number where you may be reached during normal business hours.

  Social Security Number: Required for identification purposes only.

  Additional Data: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

- ☐ ***Box #2 Previous Credentialing.*** List all credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.
- ☐ ***Box #3 Professional Experience.*** In chronological order, list all professional work experience since your Washington State credential has expired. If you need additional space, attach on a separate piece of paper.
- ☐ ***Box #4 AIDS Education and Training Attestation.*** Required by WAC 246-12-040.
- ☐ ***Box #5 Disciplinary Action Attestation.*** Required by WAC 246-12-040.
- ☐ ***Box #6 Continuing Education Attestation.*** Required by WAC 246-12-040.
- ☐ ***Box #7 Applicant's Attestation.*** Required to be signed and dated in order to process the application.

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FEE DATA (All fees are non-refundable)		
❒	Late Renewal Penalty Fee	$40.00
❒	Current Renewal Fee	$40.00
❒	Expired Credential Reissuance Fee	$40.00
	TOTAL	**$120.00**

CREDENTIAL #

APPLICATION FOR EXPIRED CREDENTIAL ACTIVATION

Please Type or Print Clearly – Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us of a change.

TELEPHONE [ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL** BUSINESS HOURS.]	SOCIAL SECURITY NUMBER (REQUIRED FOR IDENTIFICATION PURPOSES ONLY)

GENDER	BIRTHDATE	PLACE OF BIRTH
❒ Female ❒ Male		

Have you ever been known under any other name? ❒ Yes ❒ No

If yes, other name(s):

2. PREVIOUS CREDENTIALING (Since Last Being Credentialed in Washington State)

STATE/JURISDICTION	PROFESSION	CREDENTIAL			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YR ISSUED	NUMBER		
						❒ No ❒ Yes
						❒ No ❒ Yes
						❒ No ❒ Yes
						❒ No ❒ Yes

3. PROFESSIONAL EXPERIENCE (Since Last Being Credentialed in Washington State)

Nature of Experience or Practice and Location	Dates of Experience	
	From (mo/yr)	To (mo/yr)

4. AIDS EDUCATION AND TRAINING ATTESTATION (Check Appropriate Box)

I certify I have completed the minimum of: ❒ four (4); or ❒ seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years, and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my credential may be denied, or if issued, suspended or revoked.

Applicant's Initials

5. DISCIPLINARY ACTION ATTESTATION

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials

6. CONTINUING EDUCATION/CONTINUING COMPETENCY ATTESTATION (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years.

Applicant's Initials

7. APPLICANT'S ATTESTATION

I, _____, certify that I am the person described and identified in
Name of Applicant
this application; that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I have not been convicted of any criminal charges and/or suffer from any physical or mental conditions, which would jeopardize the quality of care rendered by me to the public. I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my credential to practice in the State of Washington.

Applicant's Signature _____ Date _____